INDEPENDENT CAPACITY ASSESSMENT: A CRITIQUE

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In its report and recommendations on *Research Involving Persons with Mental Disorders That May Affect Decisionmaking Capacity*, the National Bioethics Advisory Commission (NBAC) has endeavored to promote enhanced federal regulations concerning the conduct of research with psychiatric patients and ethical guidance for institutional review boards (IRBs) and clinical investigators.[1] Among the most significant and controversial of NBAC's recommendations is Recommendation 8: "For research protocols [involving persons with mental disorders that may affect decisionmaking capacity] that present greater than minimal risk, an IRB should require that an independent, qualified professional assess the potential subject's capacity to consent."[2]

NBAC's recommendation takes the form of a presumptive rule rather than an absolute requirement for independent capacity assessment, since it is qualified by the following statement: "An IRB should permit investigators to use less formal procedures to assess potential subjects' capacity if there are good reasons for doing so."[3] A potential good reason noted by NBAC for not using independent capacity assessment is lack of available independent, qualified professionals.[4]

In this article we examine critically this recommendation of independent capacity assessment and suggest an alternative approach. While independent capacity assessment may be an appropriate protection for higher risk research involving subjects with known impairments in decision-making capacity, we contend that the NBAC recommendation lacks empirical support and is too broad in scope. Instead, we favor the development and use of formal procedures, approved by IRBs, to guide investigators in capacity assessment.

The Rationale for Independent Capacity Assessment

Informed consent—a basic norm of research ethics—depends on research subjects having the capacity to make rational decisions concerning research participation. Persons who are determined to lack, or have severe impairments in, decision-making capacity are either excluded from research or enrolled on the basis of protective procedures such as advance directives consenting to research, completed when the subjects were capacitated, and/or authorization by a designated surrogate decision maker.[5] In the prevailing practice of psychiatric research, investigators and other members of the research team have assumed the responsibility of determining whether or not potential research subjects are able to give informed consent for research participation. What, then, is the rationale for recommending that this responsibility be lodged with "independent" professionals?

The NBAC report lacks a detailed justification for this important recommendation. The concern motivating it, however, is clear: namely, that the need of investigators to enroll patient volunteers in research protocols poses a conflict of interest, which has the potential of interfering with an accurate assessment of the capacity of these subjects to provide informed consent. Thus NBAC explains the rationale for this key recommendation as follows: "This requirement of independence is based on NBAC's conviction that conflicts of interest can, in some cases, distort professional judgment, and that they should be eliminated whenever possible."[6]

The NBAC report does not present any systematic data indicating that psychiatric investigators have inappropriately determined that incapacitated subjects are capable of informed consent for research participation. Rather, the report merely asserts that a conflict of interest exists that may bias professional judgment concerning decisionmaking capacity: "It is also important to recognize that investigators seeking to enroll subjects face conflicting interests, and some may become too willing, perhaps unconsciously, to label prospective subjects capable when this will advance their research interests."[7] In support of this the NBAC cites a study by Daniel C. Marson and colleagues regarding judgments of capacity to consent in patients with Alzheimer's disease.[8] The cited article, however, does not provide any direct evidence of biased judgment on the part of investigators. Marson's study compared five expert physicians on global judgments concerning the capacity of a sample of subjects to consent to medical treatment, based on viewing videotaped interviews. The sample consisted of twenty-nine patients with mild Alzheimer's disease and sixteen normal controls. Three of the five physicians found 76 to 100 percent of the patients competent to consent; the other two found 10 percent and 48 percent competent. In contrast, there was almost unanimous agreement on the capacity of the normal controls to consent.

Because this study concerned capacity to consent to medical treatment, its implications for capacity to consent to research participation are suggestive at best. More significantly, the study tested the consistency, not the accuracy or appropriateness, of professional judgments about the capacity to consent. The physician raters were not being compared with an objective "gold standard" of capacity assessment; hence, the study offers no basis for determining whether the subjects with Alzheimer's disease should, or should not, have been judged capable of informed consent. The study provides some evidence for lack of consensus among expert physicians about what counts as incompetence among mildly demented patients. It does not, however, provide any evidentiary support for the proposition that investigators are disposed to judge subjects with impaired capacity as competent in order to enroll them in research.

The only other possible evidence bearing on capacity assessment presented by NBAC derived from a review of a sample of research protocols involving subjects with mental disorders that may affect decision-making capacity that appeared to pose greater-than-minimal risk without prospect of direct benefit.[9] In addition, these studies were selected because they had a research design that included a drug washout, placebo control, or symptom provocation. Based on a Medline search of scientific articles published after 1995, NBAC identified approximately sixty eligible studies. Requests for protocol and consent documents yielded only thirteen sets of documents. With respect to capacity assessment, the NBAC report noted: "NBAC's review of protocols and consent documents failed to find evidence that researchers provide to IRBs an adequate description of how prospective subjects will be evaluated for their capacity to consent."[10]

NBAC's protocol review has obvious limitations. The low response rate of 22 percent raises doubts about the representativeness of the NBAC sample of protocols. Moreover, the lack of documentation in the reviewed protocols concerning capacity assessment does not imply that capacity assessments were either not performed or conducted in a biased fashion. At most, it suggests that the process of capacity assessment may not have received adequate explicit attention in the research plan and in IRB review for these protocols.

It appears, then, that NBAC's recommendation for independent capacity assessment was based largely on an intuition, which may or may not be accurate, that conflict of interest may be operating to bias investigators in favor of determining that psychiatric patient volunteers are capable of giving informed consent. We do not dispute the plausibility of this intuition; however, we question whether it justifies recommending a significant change in the conduct of psychiatric research.

It might be argued that to promote public accountability and trust, independent capacity assessment should be required for higher risk psychiatric research despite the lack of any systematic data indicating that this is ethically necessary or desirable. Nevertheless, several considerations make this proposition questionable. The comprehensive implementation of independent capacity assessment adds considerable expense and inconvenience, which may unduly hamper psychiatric research. To the extent that psychiatric patients are just as capable as other medically ill patients to give informed consent for research, a more exacting process of capacity assessment for the former group may be stigmatizing.[11] Finally, this requirement suggests distrust of the professional integrity of psychiatric investigators. To be sure, lack of systematic evidence indicating or suggesting abuse of professional judgments of capacity assessment by psychiatric investigators does not justify the inference that prevailing practice in this domain is ethically adequate. However, in the absence of evidence to the contrary, it appears reasonable to presume that psychiatric investigators are capable of valid judgments of capacity to give informed consent to research, especially when guided by suitable formal procedures of capacity assessment.

Comparison with Judgments of Medical Eligibility

The existence of a conflict of interest that may bias professional judgments of capacity assessment does not entail that these judgments should be made by independent professionals. The recommendation of independent capacity assessment appears to be based on a presumption that psychiatric investigators, subject to IRB oversight, cannot be trusted to manage this conflict of interest so that research subjects are adequately protected. To probe the rationale for independent capacity assessment, it is instructive to compare this issue with the analogous determination by investigators of subjects' medical eligibility for research participation. The latter raises a similar conflict of interest between the need for subject recruitment and protection of human subjects. It is standard practice for investigators to screen prospective research subjects for medical suitability, both to assure the adequacy of scientific information as well as to protect subjects from undue risks of harm. Investigators anxious to enroll a sufficient number of subjects in a study may be tempted to include subjects with conditions that place them at heightened risk. In their review of this issue, Weijer and Fuks recommend that investigators sign a statement attesting that they have screened potential research subjects and judged that they will not be placed at undue risk by research participation.[12] However, we are not aware of any recommendations that this professional judgment of medical suitability be vested in, or confirmed by, independent professionals not subject to a conflict of interest.

Just as psychiatric investigators, subject to IRB review and oversight, can be trusted to make judgments of medical suitability for research participation, we believe that they also can be trusted to undertake the responsibility for assessing capacity to give informed consent. Nevertheless, there may be relevant differences between these two sorts of professional judgments that might make a stronger case for independent assessment of decision-making capacity than for medical eligibility. Protocols typically contain clear and specific exclusionary criteria based on medical history and diagnostic tests. Current tests of capacity assessment, by contrast, lack such clarity and specificity. No consensus exists on what counts as lack of capacity to give informed consent to research.[13] One might hypothesize, furthermore, that physician-investigators as a matter of medical training and professional orientation are more likely to be concerned and scrupulous about patient safety than about strict compliance with the norms of informed consent. The maxim "Do no harm" is an ancient norm integral to medical practice; informed consent is a relatively recent requirement imposed by law and regulation on medicine and clinical research.

Accordingly, there may be grounds for greater concern with the potential for bias in judgments of capacity assessment, as compared with judgments of medical suitability for research. Yet it does not follow that independent capacity assessment is ethically required. Formal procedures to guide investigators in assessing capacity might serve adequately to ensure unbiased judgments. In any case, it is worth noting that if it is

appropriate to permit investigators to make clinical judgments about medical eligibility for research, then it is not always necessary to eliminate conflicts of interest by requiring independent assessments.

Scope of Independent Capacity Assessment

The scope of a recommendation for independent capacity assessment is worth probing, in addition to raising questions about the rationale for making this a requirement. The NBAC report recommends independent capacity assessment for all greater-than-minimal-risk research involving subjects with mental disorders that may affect decision-making capacity. The range of mental disorders that may affect decision-making capacity is not clear in the NBAC report. It discusses some, but not all, diagnostic categories of mental disorders that may place persons at risk of loss of decision-making capacity.[14] Furthermore, within the designated class of mental disorders that may affect decision-making capacity, disease severity is likely to be a critical variable. Because some depressed patients may have impaired decision-making capacity, does it follow that all greater-than-minimal-risk research with depressed subjects should deploy independent capacity assessment, regardless of disease severity? Just as NBAC argues that it would be too restrictive to require independent capacity assessment for all psychiatric research regardless of risk,[15] so it may be too restrictive to require this for all greater-than-minimal-risk research involving subjects that belong to diagnostic groups of mental disorders that may affect decision-making capacity: e.g., clinical trials involving outpatients diagnosed with major depression. If independent capacity assessment is required, it should be limited to specific study samples of research subjects with conditions that are likely to produce compromised decision-making capacity.

Implementation Issues

The NBAC report provides scant guidance on operationalizing the recommendation of independent capacity assessment. What counts as independence is not specified. For example, can professionals employed by the research institution who are not members of the research team conduct independent capacity assessment? If qualified independent professionals should not be employees of the research institution, how will they be recruited and compensated so as to assure independence?

The NBAC recommendation for independent capacity assessment is tied to individual protocols. Discrete protocols, however, are often linked together in the context of research programs.[16] For example, patients may be recruited for a drug treatment study that includes an initial medication-free phase ("washout"). During the washout period, patient volunteers may be asked to participate in a variety of studies that have no therapeutic components, such as imaging protocols with positron emission tomography or "challenge" studies with pharmacologic agents, designed to elicit and measure psychiatric symptoms and other neurobiological responses. These procedures may be repeated after the patients have completed the treatment study. If psychiatric

patients are approached simultaneously, or within a short period of time, for two or more linked protocols that are more than minimal risk, is independent capacity assessment required for each? Multiple independent or formal capacity assessments with the same group of subjects within a limited period of time is likely to be inconvenient and unnecessary. On the other hand, if independent capacity assessment is required only at the entry into a research program consisting of linked protocols, this may not provide sufficient subject protection. If patients already enrolled in research are to be invited to participate in additional higher risk protocols that lack a prospect of direct benefit at a time when their decision-making capacity is likely be compromised—e.g., during a drug washout phase—formal capacity assessment, which may include the judgment of an independent professional, should be repeated.

An Alternative Approach

The lack of a convincing rationale for independent capacity assessment, coupled with concerns about the scope and implementation of this recommended safeguard, suggest that it is premature to make independent capacity assessment a requirement of all greater-than-minimal-risk psychiatric research. As an alternative, we recommend that investigators be required to specify to IRBs how they propose to conduct capacity assessment, preferably with some formal process using a validated instrument or a test of comprehension and perhaps videotaping. Investigators should report to IRBs periodically on the number of potential patient volunteers with disorders that may affect decision-making capacity that have been screened and the number found capable or lacking capability to give informed consent. Additionally, professional journals should require that authors of scientific reports of research involving patients with disorders that are likely to impair decision-making capacity, such as Alzheimer's disease and schizophrenia, indicate their methods of assessing capacity to give informed consent.[17] Before initiating a regulatory requirement of independent capacity assessment, empirical research should be conducted across diagnostic groups of patients with mental disorders to shed light on the prevalence of impaired capacity and the need for independent capacity assessment. In the meantime, IRBs currently have the authority to require independent capacity assessment for studies in which this safeguard is judged warranted.

Promoting Professional Integrity

Inherent in all clinical research are tensions or conflicts between advancing science and professional careers on the one hand and protecting the rights and well-being of human subjects on the other. These tensions or conflicts arise at the outset of research—in decisions concerning medical eligibility and capacity to consent—and during the course of research, when investigators must decide whether or not to suspend or terminate research participation for patient volunteers who experience disease worsening or adverse reactions. It is neither practicable nor desirable to attempt to

eliminate all these conflicts by vesting such key decisions in professionals independent of the research. We contend that as a general rule it is preferable to promote and enhance the professional integrity of investigators and other members of the research team, so that these tensions and conflicts can be managed in an ethically appropriate manner.[18] This calls for cultivating awareness and reflection concerning the contexts in which these tensions and conflicts arise and responsibility to protect the rights and well-being of research subjects. Education in the ethics of clinical research, IRB review and oversight of research protocols, and ethical discourse among members of the research team can contribute to promoting professional integrity.

Conclusion

Childress and Shapiro recently observed, "As commissioners, we see the NBAC report as part of a continuing societal conversation...about what regulations should govern research involving persons with mental disorders that may affect their decisionmaking capacity."[19] Although we have questioned the merits of NBAC's recommendation concerning independent capacity assessment, we believe that the NBAC report has performed a valuable public service by stimulating reflection and debate on the complex ethical issues surrounding psychiatric research.

*The opinions expressed are those of the authors and do not necessarily reflect the policy of the National Institutes of Health, the Public Health Service, or the Department of Health and Human Services.

Endnotes

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2. *Ibid.*, p. 58.
3. *Ibid.*, p. 58.
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CRITIQUE OF THE RECOMMENDATIONS OF THE NATIONAL BIOETHICS ADVISORY COMMISSION'S REPORT ON RESEARCH INVOLVING PERSONS WITH MENTAL DISORDERS THAT MAY AFFECT DECISIONMAKING CAPACITY

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The National Bioethics Advisory Commission (NBAC) attempted in their December 1998 report to resolve long-standing serious ethical problems that have been pervasive in psychiatric research. The commission truly missed a historical opportunity to influence the ethical terrain in general in our country and forbid once and for all certain narrowly defined nontherapeutic harmful and degrading experiments on the most vulnerable segment of our society. Numerous philosophers, religious leaders, and thoughtful individuals have said that civilizations are judged by how we treat the most vulnerable and disabled individuals among us. In a nation where profit interests have an overwhelming influence on the national discourse, NBAC could have provided that ethical secular voice missing from our national debate.